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ABSTRACT

This paper discusses home visiting programs for low income parents and infants and describes five such programs known collectively as the Child Survival/Fair Start (CS/FS) projects, funded by the Ford Foundation. It describes a conceptual model which links risk factors and intervention activities to effects on mothers and children and explains how interpersonal intervention through home visits sets out to change maternal behaviors--use of available health care, habits of self-care and nutrition, and skill and sensitivity as a parent--and thereby improve child health and development outcomes. Basic elements of a home visiting program are discussed, including education to provide information, advice, and role-modeling; practical assistance to increase the mother's access to services; and social support activities to increase her motivation to apply that knowledge. The five CS/FS programs served the following populations: migrant Mexican farmworkers in southernmost Florida; young Black mothers in rural Alabama; isolated families in Appalachia; recent Haitian immigrants in south-central Florida, and Mexican families in Austin, Texas. The ensuing discussion touches on three particularly important issues: (1) meshing, not competing, with the mother's existing support system; (2) providing support that creates self-confidence and not dependence; and (3) coping with the variability in program effectiveness that results from differences in the nature and evolution of supportive relationships. The paper concludes with an overview of the results of CS/FS program evaluations. Paper copies of presentation slides are included. (TE)

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SOCIAL SUPPORT PERSPECTIVES ON PROGRAMS FOR PARENTS
LESSONS FROM THE CHILD SURVIVAL/FAIR START HOME VISITING PROGRAMS

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Home visiting programs have become an increasingly popular strategy for reaching pregnant women and new mothers to link them to the formal service system, encourage them to improve health habits and nutrition, and stress the importance of providing both nurturance and stimulation to their infants. In their goals and services, these programs blend aspects of directive intervention with the acceptance and encouragement that are characteristics of informal social support. Over the past decade or so, as research on the beneficial effects of social support has accumulated, emphasis on the supportive elements of what were once called "intervention programs" has grown, as well. The concept of social support plays an especially salient role in home visiting programs because they focus on personal relationships established between program workers and the families in the program. Yet we have only a general understanding of how such "intentional" social support affects families.

To gain a practical perspective on the use of social support to achieve programmatic goals, I want to share with you some insights gained through my work with a set of five home visiting programs for low-income parents and infants known collectively as the Child Survival/Fair Start (CS/FS) projects. These were demonstration programs, funded by the Ford Foundation and started from scratch in a wide variety of the nation's poor communities. My High/Scope colleagues and I were charged with providing technical assistance to the projects and conducting selected cross-project evaluation activities. The insights I will be sharing with you today reflect the work and experience of the entire CS/FS network.

To provide a common framework for examining the role that home visiting programs can play in preventing problems, we developed a conceptual model linking risk factors and intervention activities to effects on mothers and

children (See Figure 1). On the left are traditional indicators of risk -- characteristics of the community and service system, and family demographics associated with deficits in child health and development. The link between these risk factors and child outcomes is thought to be mediated to some degree by behaviors that lie within the mother's own control -- her use of available health care, her habits of self-care and nutrition, her skill and sensitivity as a parent. It is these maternal behaviors that an interpersonal intervention sets out to change, trusting that those behavior changes will improve child health and developmental outcomes.

The next slide (See Figure 2) shows our hypothesis about the mechanism set in motion by an effective home visiting program. Three basic elements are interwoven in the home visiting relationship: education (information-sharing, advice, role-modeling), practical assistance (linkage to formal services, help resolving crises, transportation in emergencies), and social support (active listening, sharing personal experiences, creation of a trusting personal relationship). In combination, these three elements can increase the mother's access to servies, increase her knowledge of appropriate behaviors, and increase her motivation to apply that knowledge in concrete actions.

The "education" elements of the program are typically the vehicle for the program's directive, intervention goals. Home visitors use a variety of techniques (filmstrips, pamphlets, demonstrations, suggestions, and explanations) to persuade the mother of the importance of following the program's advice. At times, however, it is not knowledge but motivation to change behavior that is the missing element. The program's "practical assistance" and "social support" combine to engage the mother's attention and to give her a stake in the home visit and the relationship she develops with the home visitor, thereby increasing her willingness to make changes.

The CS/FS programs initially emphasized not support but health and parent education -- most believed in the power of information to bring about change. Over time, they focused more and more on providing support, and discovered it can be a comparatively complex undertaking. After briefly describing the CS/FS programs, I will touch on three issues that proved particularly delicate and important: (1) meshing, not competing, with the mother's existing support system; (2) providing support that would build self-confidence without creating dependence; and (3) coping with the variability in program effectiveness that resulted from differences in the nature and evolution of supportive relationships. Finally, I will give you an overview of the results of the CS/FS program evaluations.

The CS/FS Programs

The CS/FS programs were established to address issues related to birth and infant health and development among families that were poor and underserved by traditional human services. As Table 1 shows, their target populations included migrant Mexican farmworkers in southernmost Florida; young black mothers in the poorest counties of rural Alabama; isolated families in the mountains of Appalachia; recent Haitian immigrants in urban and rural settings in south-central Florida; and Mexican-origin families living in the barrios of Austin, Texas. Together, the five programs served families in twelve counties, reaching over 1,000 homes. Among the 800 studied in evaluations, about one-third of the participants were first-time mothers, fewer than a third were teenagers, most had less than a tenth grade education, and half lived in homes with no telephone.

The multidisciplinary programs were operated by a range of agencies close to the families they would serve: community health clinics, child care and social service agencies, and small independent organizations. The

projects varied in their specific goals and approaches, but they shared a common preventive strategy:

(1) They focused on families in poor communities rather than individual families at special risk.

(3) They integrated information and assistance related to health and developmental concerns in a single, generalist approach.

(2) They provided low-intensity services (bi-weekly or monthly home visits) to parents over a long period of time (from pregnancy until one or two years after the child's birth).

(4) They employed community workers as primary staff who worked with families; these workers provided one-to-one education and support, and made relevant referrals for professional services.

Parents were enrolled in most Child Survival/Fair Start programs as early as possible during pregnancy and most stayed involved until the baby's first or second birthday. (See Table 2.) They received regular home visits from a trained woman with roots of her own in the community, and occasionally they attended group events like picnics or discussion sessions. In some projects, visits were made monthly; in others they were made every one or two weeks. The average number of visits completed ranged across projects from 8 to over 30.

Home visits represent a reaching out to the family -- both physically and psychologically. They do not require the family to actively seek support, and they offer a less threatening environment for discussions of personal matters like pregnancy and childrearing than most agency settings can provide. Home visits also give workers rich insights into the physical and social factors that influence childrearing, and those insights can make the workers' suggestions more realistic and relevant. Most important, they provide the sustained, one-to-one contact that allows a trusting mutual relationship to develop.

When the home visitor entered the family's home, she usually spent a while catching up with the mother on what happened since her last visit, getting a sense of what might be on the mother's mind. Then she shifted gears to get involved in the "educational" part of the visit, discussing the health or child development topics that she had planned to go over and often involving the mother in an activity like a prenatal exercise or an infant game. Then the visit usually wound up with a more relaxed time of sharing about mutual acquaintances and social activities, or about feelings or personal problems. The visitor emphathized with the mother and helped her come up with ways of dealing with difficulties.

All the projects also linked participants to formal services, from food stamps to GED programs to counseling services to medical care. However, beyond helping families with paperwork, the projects differed in the amount of leverage they had over the medical care available to their participants. Several projects were sponsored by clinics, and there the program workers were insiders with some institutional clout. They could arrange for mothers or babies to be seen if special concerns arose, help with transportation, and bring down barriers that separated families from the professional care they wanted and needed. By contrast, the staff of the independent projects had no influence over the health care providers. Prenatally, their attention focused on good self-care practices (nutrition, smoking cessation, exercise, etc.), as the staff tried to help the mother help herself by understanding her pregnancy and minimizing risks. After the birth, all the projects helped the mother to see and encourage the baby's development, focusing on simple messages like "talk to your baby", and suggesting ways other than hitting to manage the behavior of toddlers.

The CS/FS projects employed community workers as home visitors, to give the program a local face, ensure sensitivity to cultural values, and develop

the skills of community members. The step taken by these local women from neighbor to home visitor was a large one, however, and good training and supervision were crucial as they tried to become effective in their challenging and ambiguous new roles. It is easy to underestimate the difficulty of mastering a wealth of specific information on health and child development while learning how to behave as a program worker charged with visiting other women (cousins, neighbors, or strangers) to give them advice, assistance, and emotional support. As one home visitor recalled:

> I was scared and nervous at first. I had been through the training but I was afraid I was not going to do it right. When I go in to meet the person, was I going to be friend enough for that person? Would they see through me? And I was afraid of what I was going to do for a lesson -- was I going to do it right? Was she going to really be interested?

We may think of these programs as reproducing the natural interactions that occur among neighbors and friends and infusing them with additional up-to-date information, but in fact, the home visitor is employed to visit people she would probably not otherwise see, to intentionally be supportive, and to encourage her "hostess" to adopt new behaviors. Such a relationship is less authoritarian than an encounter with a physician in an examining room, but it is not a "natural" social tie between equals.

The Difficulty of Providing Social Support

Not only is the home visiting interaction different from naturally-occurring exchanges between friends and relatives, at times home visitors find themselves in competition with those very people. The CS/FS programs learned that by targeting entire communities instead of selecting families who were especially isolated, the families they served differed widely in the type of support they wanted and needed. A small group were basically without close ties but others were already surrounded by strong and

influential networks. Some were in conflict with the key members of their networks (especially pregnant teens whose relations with their disappointed parents had broken down), though those tense relationships remained very important.

Each group perceived and responded differently to the offer of support from an "external" source. Sometimes the home visitors offered isolated mothers a first chance to experience a balanced and nurturing relationship, then urged them to form other ties (some have called this process "reparenting"). In contrast, the group of well-supported women might be expected to have little interest in the home visitor, yet many participated enthusiastically. They tended to value the visitor's expertise and contacts; she usually had access to knowledge and influence that the mother's kin and friends lacked. Such parents used the program for instrumental more than emotional support.

For those whose ties were disrupted by life transitions or conflicts, the home visitors could step in and offer support until tensions subsided. Often the young women looked up to the visitors as role models -- an alternative image of adulthood. At times, visitors were caught in a struggle for the young woman's affections that benefitted no-one. Most recognized this danger and could identify with the grandmothers. As one said: "you can't help but be a little jealous, with your daughter opening up and talking to a stranger when she won't talk to you". It became especially problematic when the visitor's advice conflicted directly with the grandmother's (as often happened with regard to infant feeding), and the young mother was left to choose which "significant other" to heed. The very offer of support can cause trouble.

The second major support issue confronted by the CS/FS programs

concerned the balance between empowerment and dependency. The staff learned that support is not invariably positive; too much assistance can trigger dependence and undermine self-esteem. As one visitor commented "we have to be careful about providing too much, even with something like transportation. The more people can do for themselves, the better they feel about themselves, and the less they feel the other person has taken over their lives." Even naturally-occurring support can backfire in this way: recent research has shown that talking about problems with intimates is associated with more, not less depression, perhaps because dwelling on troubles inhibits more active efforts to resolve problems.

The most helpful aspect of informal social support appears to be the affirmation provided by close relationships. Feeling valued by other people contributes to confidence and self-esteem, and those personal resources, in turn, help people cope with their problems and rise above them. In other words, it may be not so much the fact that the visitor shares in long discussions about the mother's problems that is helpful. Instead, it may be her genuine interest and her concern for the parent as an individual that boosts that parent's self-esteem.

This distinction between types of support can be crucial for lay home visitors to understand as they strive to manage their ambiguous role as a friend to strangers. Some CS/FS visitors were insecure about their skills and tried to help those they visited in as many ways as possible, to show they had something to offer and win acceptance -- "earning" the mother's friendship. By pressing their assistance on mothers and not realizing that it is their interest and esteem that matters the most, home visitors may be undercutting the effectiveness of their own work.

Finally, in contrast with the straightforward delivery of an educational intervention, there is an untidiness -- a variability --

associated with providing support that the CS/FS projects found hard to handle. If it is the existence of a trusting relationship between the visitor and mother that opens the door for program impacts, then establishing and protecting such relationships must be a top priority. Yet, how does one train lay workers to establish deliberate, supportive relationships without turning them into professional social workers? Focusing some training sessions on the dynamics of home visiting helped, as did team discussions of the wide range of relationships that evolve with different clients. Individual visitors gravitated toward certain roles with their clients (some focused on teaching, others preferred to help in crises), but the mothers in each visitor's caseload came to the program with different interests and needs. As a result, some relationships "clicked" and others didn't.

Moreover, all relationships evolve over time, and a period of exploration and testing usually precedes the sought-after feeling of trust. That means, however, that during the early weeks and months of their contact the visitor is likely to have relatively little influence with the mother (especially a community worker who lacks the halo of professional authority that surrounds a nurse). This can limit the power of the home visiting program to change the mother's behavior during pregnancy, to affect the habits of smoking, drinking, eating, and exercise that can make such a difference in both maternal and newborn health. Fortunately, many mothers forged relationships with their visitors relatively quickly, they tended to be themselves concerned about the pregnancy, and often the prenatal visits were more comfortable than those focused on the baby. To the CS/FS workers, pregnancy was an excellent time to begin a relationship, but many felt they had more leverage with the mothers later on.

Program Effectiveness

Despite these complexities, the CS/FS projects fielded programs combining support and intervention, and each was evaluated. The separate project teams assessed program effects on a wide range of outcomes (most notably on use of health care, birth status, parental childrearing, and cognitive development), and this brief paper cannot do those evaluations justice. However, Table 3 presents a summary look at the outcome domains in which positive program effects emerged for each of the five projects.

In three projects, program mothers received more appropriate prenatal care, initiating it earlier or seeing the doctor more frequently. Their babies were similar in size and general health to those born to comparison mothers, however, showing that the programs did not influence the biological health of the newborns. After the birth, the program mothers in two programs turned out to be better users of pediatric care for their infants, they came to the doctor for more well-child check-ups and had their children immunized earlier than comparison mothers.

The programs with the strongest effects on use of health care were, not surprisingly, those that were based in clinics. There, the staff not only stressed the importance of health care to the mother, they were able to lower some of the institutional barriers that keep families from using health care by helping with paperwork, translation, and transportation, and by pressing for change in clinic policies (eligibility rules, appointment schedules, and so forth). Programs that lacked that "insider" status with the health care system found their education and encouragement had no impact on many of the real reasons families failed to use health care.

In part, this success shows how motivated most women are to have medical supervision of their pregnancies; a relatively modest amount of

assistance paid off in increased use of prenatal care. The projects also strove to improve the health habits of the pregnant women (nutrition, exercise, smoking, and drinking) but only one succeeded. It is not easy to change routine, private behaviors that carry medical risks but provide valued personal satisfactions. Of course, the brusque recommendations medical staff make during clinic visits do little to encourage behavior change either, however, so the modest success of the CS/FS programs in this area should not be taken lightly.

Effects on Parenting and Child Development

The mothers in three projects changed caregiving behaviors in response to the programs' encouragement. In two projects, more mothers tried breastfeeding; and in two projects, mothers adopted a more active parenting role by talking and playing with the baby and providing a safe environment for exploration. And three projects found that the infants served by the program were more alert and competent than comparison infants when tested at one or two years of age. The projects that produced these effects on childrearing and parent-child interaction were not closely affiliated with the health care system -- both parents and staff viewed the programs as focused on issues of parenting rather than on health.

While several CS/FS projects were successful in this area, all learned that it is difficult to change patterns of parenting. Many mothers feel confident that childrearing comes naturally and needn't be learned. When there is no clear threat to the infant's health or safety, parents see little reason to deviate from the habits of their own parents: "that's how my mama did me, and I turned out fine". The concrete assistance that can do so much to increase use of health services does not play a major role in encouraging parents to play and talk with their babies to spur early

learning. And many home visitors were uncertain about what to say or do to encourage active parenting; giving guidance in this area is far less cut and dried than is a reminder to take your prenatal vitamins or be sure the baby gets his shots.

Appropriate Expectations

The CS/FS programs worked with parents, in the belief that changes in the parents' attitudes and actions toward their children would benefit the infants by protecting their health and fostering their development. The programs were extensive, offering regular supportive contacts over two years and more. Yet in intensity, a one-hour visit every two weeks is a much weaker program than one offering three or five day-long sessions at an infant program or in a parent-child center. Perhaps more importantly, programs like these rely on a "domino effect". Program developers train staff in key areas, staff members then explain and coax parents to try out the new ideas or approaches, and only if the parents actually act differently at home will any program effect reach the child. Yet when parents do change, the impact of those changes can be long-lasting and can touch more than just the target child.

Nonetheless, there are limits to the benefits we can expect to see from comparatively modest, multi-purpose programs like these. Poverty and cultural barriers intrude on the private lives of families, undermining health, straining parents' ability to cope, and making childrearing a struggle. Even if they are vigilant, parents have little control over many threats to the healthy development of their children. There is no quick fix to the problems faced by families in poverty and we can forfeit our credibility with families by acting as if we, the experts, have easy answers or guaranteed solutions.

By earning the trust of a parent and working together to solve problems and understand what will be best for the child that both are concerned with, however, home visitors can set a long-term process in motion. The CS/FS staff felt that subtle changes in self-esteem usually lay behind changes in the mother's childrearing practices or her use of formal services. As one young participant said:

> I feel like having a home visitor, it helped me a lot because without her encouraging me to hold my head up and go on, I don't think I would be where I am today. I would still be holding my head down, thinking that I'm nobody. Now I feel like I'm somebody since I've had people talk to me and encourage me.

As one program director explained, changes in parent behavior come about not because of specific home visit activities but "because of what goes on in the mother's head". It is there that parent programs make a difference.

Figure 1

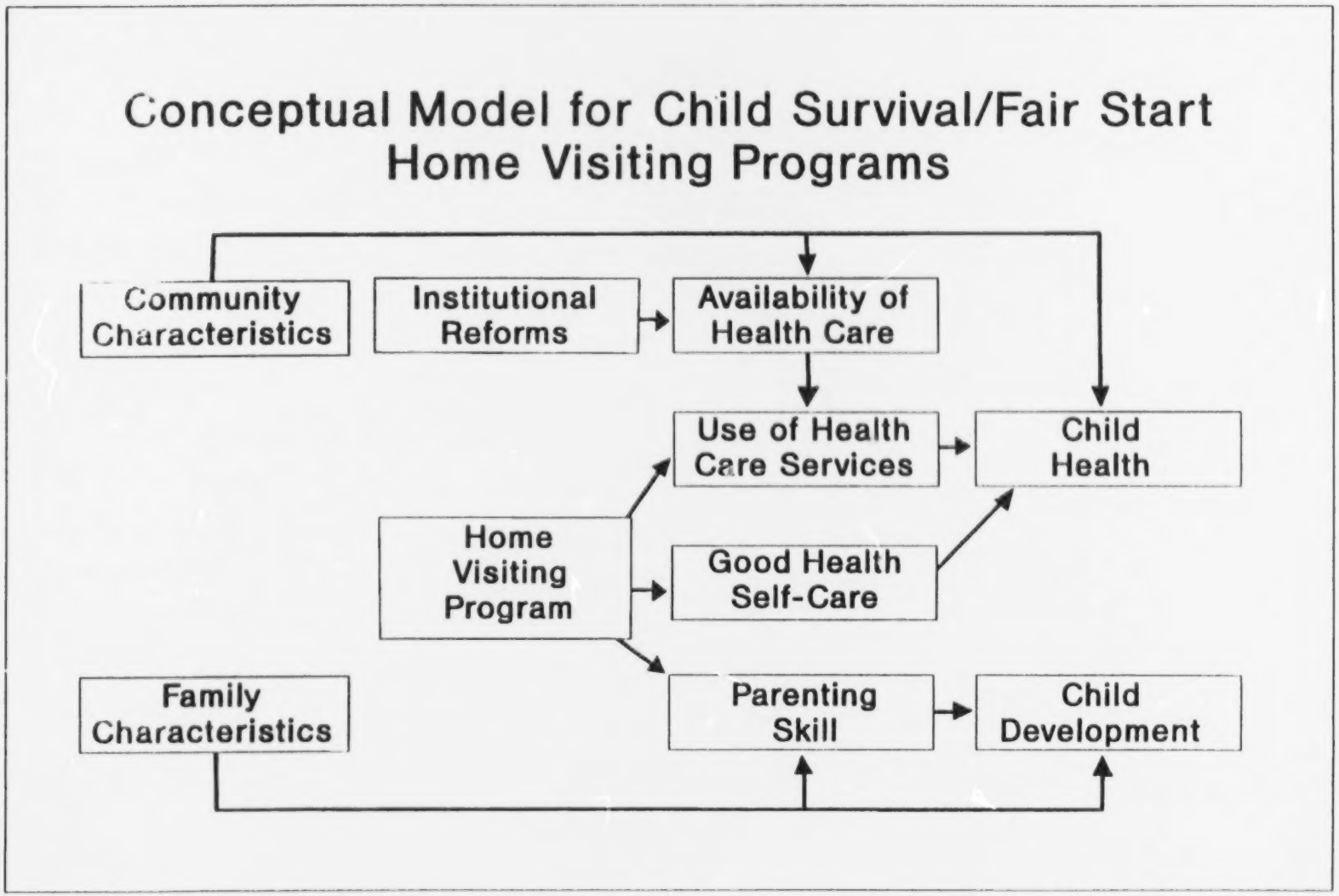
Conceptual Model for Child Survival/Fair Start Home Visiting Programs
Community Characteristics
Institutional Reforms
Availability of Health Care
Use of Health Care Services
Child Health
Home Visiting Program
Good Health Self-Care
Family Characteristics
Parenting Skill
Child Development

Figure 2

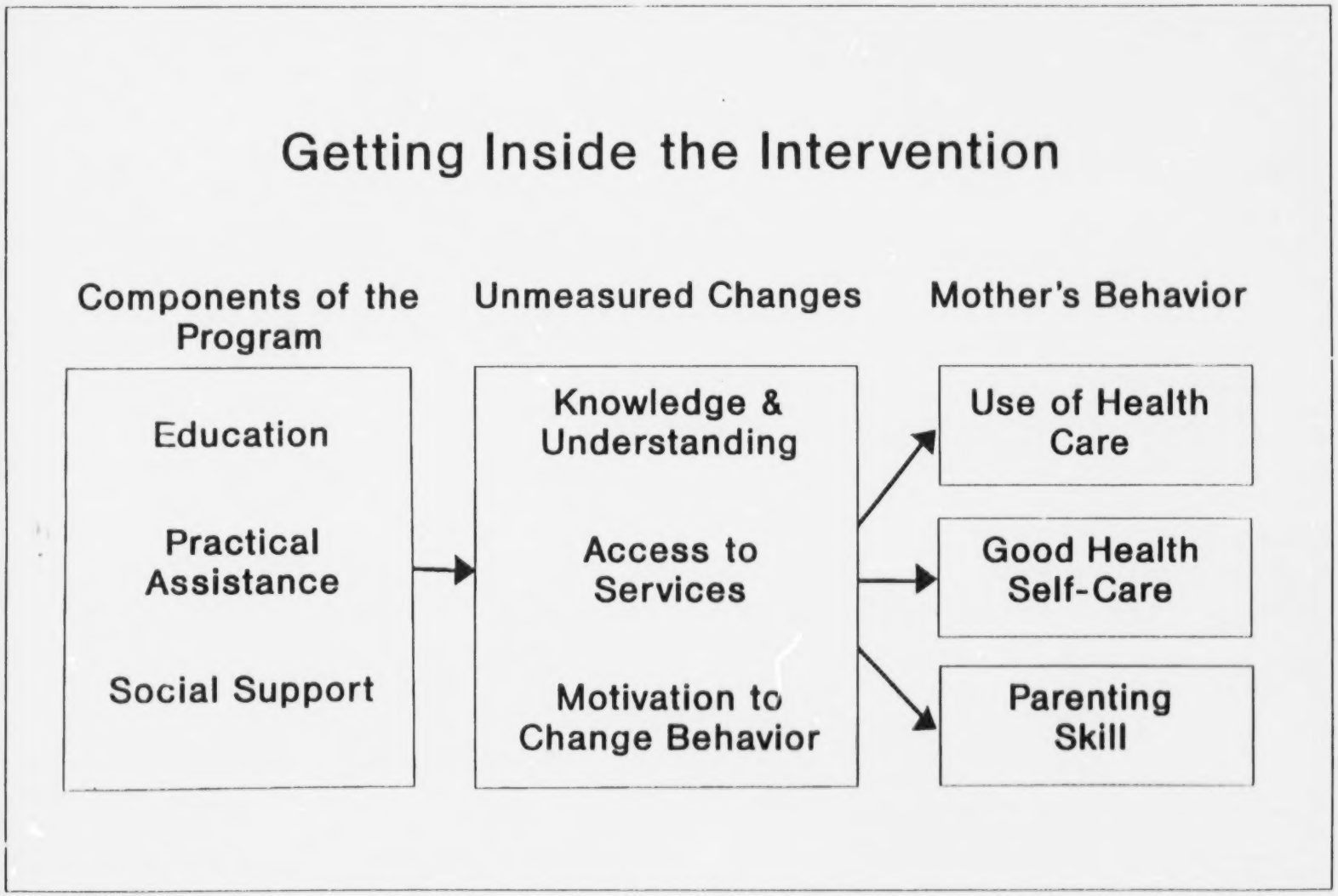
Getting Inside the Intervention
Components of the Program
Unmeasured Changes
Mother's Behavior
Education
Practical Assistance
Social Support
Knowledge & Understanding
Access to Services
Motivation to Change Behavior
Use of Health Care
Good Health Self-Care
Parenting Skill

Table 1

Populations Served by the CS/FS Home-Visiting Programs

	Migrant Project	Alabama Project	Appalachian Project	Haitian Project	Texas Project
Community type	2 rural migrant camps	2 rural counties	5 rural areas	2 counties 1 urban, 1 rural	2 urban "barrios"
Number served into infancy	108	88	413	100	113
Mother's age	23 years	22 years	20 years	28 years	24 years
Mother's education	7 years	12 years	10 years	6 years	8 years
Percent married or cohabiting	70%	24%	68%	82%	77%
Percent having first pregnancy	31%	57%	35%	19%	27%

Table 2

Program Services Offered in CS/FS Home-Visiting Programs

	Migrant Project	Alabama Project	Appalachian Project	Haitian Project	Texas Project
Sponsoring agency	health clinic	health clinic	health clinics, community organizations	developmental center	family resouce center
Timing of entry	pregnancy	pregnancy	pregnancy	pregnancy	infancy
Duration of program	1.5 years	2.5 years	2.5 years	2 years	1 year
Home visit schedule	varied	biweekly to monthly	monthly	weekly to monthly	weekly or biweekly
Average number of visits received	8.4 visits	20.5 visits	21.3 visits	33.9 visits	22.5 visits

Table 3

Summary of Program Impacts

	(Clinic sponsored)		(Independent)		
	Migrant Project	Alabama Project	Appalachian Project	Haitian Project	Texas Project
Prenatal Care					
Early entry	close	no	no		
Number of visits	no	yes	yes	no	
Birth Status					
Full-term births	no	no	no	no	
Birth weight	no	no	no	no	
APGAR score	close	no	no	yes	
Parent Behavior					
Well-child care	yes	yes	no		
Immunizations	yes	yes	no		no
Breastfeeding	yes	no	close		
Home stimulation	no	no	yes	no	no
Play interaction				yes	
Child Development					
Bayley test		no		yes	yes
Denver screening			yes		

Key: blank = not relevant to this project, or not measured
no = no program-favoring effect found
close = program-favoring effect, significant at $p<.10$ level
yes = program-favoring effect, significant at conventional $p<.05$ level